STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155719	A. BUILDING 01 B. WING	11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 E SR 16 BROOK, IN47922

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/22/11 Facility Number: 000559 Provider Number: 155719 AIM Number: 100267170 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, George Ade Memorial Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (222)	K0000	Re: POC for the annual survey of George Ade Memorial Health Care Center, Brook, IN. Survey Event ID 6VUC21 Dear Miriam Buffington: This letter is in regards to the aforementioned survey that was conducted on November 22, 2011. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 22 nd day of December 2011. After that time we are requesting the Indiana State Department of Health conduct a follow-up survey and/or accept this information for paper compliance to clear the findings and stop any and all proposed or implemented remedies that have been presented to date. If you have any questions or need further information, call 219-275-2531 or fax 219-275-7472, and we will be available to assist you in any way possible. Thank you, W R Scott James, HFA GAMHCC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity for 70 and had a census of 56 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/01/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:		This plan of correction is prepared and submitted solely because it is required by the State and Federal law, and not because the Provider agrees with the allegations made in the survey document. In fact, the alleged deficiencies do not, either individually or collectively, demonstrate the facility's resident's health, safety or welfare is compromised or that this Provider is incapable of rendering all necessary and beneficial nursing care and services. This plan of correction constitutes the Provider's allegation of compliance. Completion dates are provided because they are required by State and Federal law, and to correlate with accomplished correction action, in the context of the survey process. To the extent possible, permissible dates, i.e. dates after the surveyors left the facility, were assigned.	

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K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice affects visitors, staff and 44 residents of the EC and MS units. Findings include: Based on observation with the maintenance director on 11/22/11 at 1:00 p.m., one door in the the fire door set near the dining room failed to close upon activation of the fire alarm system by the maintenance director. The	K0021	· The door hold magnet has been replaced as of 11/30/11 and is functioning properly. · The fire panel system has been checked and all magnetic door holders are functioning properly as activated by the alarm system(s). · The magnetic door releases are visually checked with each alarm test, to see that they are functioning properly, so as to prevent reoccurrence. Any repairs/changes are completed upon review of a defective device. · The Maintenance supervisor and or designee will check each device during normal maintenance and testing of the system(s) to prevent further occurrences. · Done as of 11/30/2011.	11/30/2011

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	maintenance director said at the time of observation, he could not explain why the magnet holding the door open failed to release upon activation of the fire alarm. 3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles with a total capacity exceeding 32 gallons capacity within any 64 square foot are stored in a room protected as a hazardous area in 1 of 8 smoke compartments. This deficient practice a affects visitors, staff and 28 residents on the MS unit. Findings include: Based on observation with the	K0029	· Barrels have been removed from the cited rooms, and are no longer used in any resident rooms. · Barrels of 28-32 yellow size will no longer be used in resident rooms for isolation procedures. Containers of proper size have been ordered to not exceed the recommended size for resident room use. · Containers of the correct size will now be used for isolation procedures. This will prevent further recurrence. · The Housekeeping supervisor and DON or designee will be responsible to see that the correct	12/22/2011

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	maintenance director on 11/22/11 at 1:40 p.m., two 28 to 32 gallon soiled linen and trash receptacles were observed through the open resident room door of room 24. The receptacles were half or more full and had the capacity for 28 to 32 gallons. The door had no self closing device. The maintenance director said at the time of observation, the receptacles were for special isolation trash and soiled linen collection. 3.1-19(b)		items are used in isolation procedures. i.e.: containers · This is done as of 12/22/2011.	
K0048 SS=C	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to provide a complete fire protection plan which included the use of fire extinguishers and evacuation sites within the facility for the protection of 56 of 56 residents in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:	K0048	· The fire policy is current with staff members aware and able to implement the policy as needed. The fire extinguishers noted in the kitchen area have been changed to now include ABC type extinguishers for proper use. · Proper fire extinguishers are available throughout the facility with proper types as required. · All extinguishers are checked on a monthly basis for proper condition and location. · In-service provided on 12/8/2011, contained	12/06/2011

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	(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents in the facility. Findings include: Based on observation with the maintenance director on 11/22/11 between 11:50 a.m. and 1:50 p.m. three types of portable fire extinguishers were provided for use in the facility. Based on a review of the facility's written Fire Procedure on 11/22/11 at 2:45 p.m. with the maintenance director, the plan did not address the use of the ABC type fire extinguishers, deionized water fire extinguishers and the K class fire extinguishers located in the facility. There was no evidence of training for their use. In addition, when the cook was interviewed on		proper use of fire extinguishers. · The Maintenance supervisor or designee will maintain and check each fire extinguisher throughout the facility on a monthly basis to assure proper and functional fire extinguishers are in place. Any found to not be in proper working order will be replaced immediately to avoid further concern. · This is done as of 12/6/2011.	

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	11/22/11 at 12:25 p.m. to ask how she would handle a fire occurring on a stack of cloth napkins located on a shelf in the kitchen near her, she said she would extinguish it using one of two K class fire extinguishers located in the kitchen. A placard located above each K class extinguisher gave specific direction for it's use which would not have been appropriate for a napkin fire. The maintenance director agreed at the time of observation, interview and record review; the fire plan was not complete and more training would be needed for the staff. 3.1-19(b)			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct fire drills at varied times	K0050	. Fire drills will now be varied more than the current practice as noted.	12/06/2011

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	during 4 of the past 4 quarters. This deficient practice affects all occupants. Findings include: Based on a review of Fire Drill Reports with the maintenance director on 11/22/11 at 2:55 p.m., third shift (11:00 p.m.-7:00 a.m.) drills were conducted at 4:30 a.m., 5:00 a.m., 5:30 a.m. and 5:45 a.m. during the past year. Second shift (3:00 p.m.-11:00 p.m.) drills were done at 3:15 p.m. (twice), 3:17 p.m. and 3:35 p.m. during the past year. The maintenance director agreed at the time of record review, there wasn't much variation in the times training was conducted each shift. 3.1-19(b) 3.1-51(c)		· Fire drills are conducted on all three (3) shifts as required in varying times so as to not provide a notable pattern of predictability. · The variation will be ongoing to prevent further concerns. Drill times will vary with each quarterly drill. · Administrator or designee and Maintenance supervisor will be responsible to see that the drills are conducted appropriately. · This is done as of 12/6/2011.	

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K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen storage sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Installation of Sprinkler Systems, in 5-5.6 requires the the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects 4 occupant in the kitchen. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:15 p.m., the ice machine in the kitchen storage room was located 10 inches from the only sprinkler head providing protection for the room. The maintenance director said at the time of observation, he did not realize the sprinkler head was less than the minimum distance	K0062	· The following information provided explains the reasoning for the sprinkler installation in the pantry area. · Section 5-5.6 of NFPA 13 is dealing with clearance to **storage**, which this case does not pertain to. The ice maker's footprint is less than 4 sq. ft. (22 ½" wide x 24" deep) with the head located approximately in the "quarter point" of the ice maker (see attached sketch). Figure A.5.5.5.1 pertains to the spray pattern of a Standard Spray Upright or Pendant Sprinkler. The full development of the sprinkler pattern extends at a 4'-0" radius from the sprinkler at a distance of 18" below the deflector. In this instance, the deflector is 11" from the top of the ice maker and approximately 18" from the farthest edge of the ice maker. The full development of the sprinkler pattern at 11" below the deflector is at a radius of 29.33" from the center of the sprinkler – well outside the footprint of the ice maker. · This room is 103 sq. ft. (8'-8" x 10'-11"). With a horizontal distance of only 35'-0" from the discharge of the fire pump, this particular sprinkler head will be discharging at a rate	12/05/2011

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	allowed between a sprinkler head and an obstruction. 3.1-19(b)		of approximately 51 Gallons Per Minute (GPM), resulting in a sprinkler density of 0.50 GPM/sq. ft – far beyond what is required for a dry food storage room (Ordinary Hazard, Group I occupancies require a density of 0.15 GPM/sq. ft.). If the sprinkler head in the Food Storage room were ever to activate, the area would literally be flooded and a fire very quickly extinguished. · We would ask that this information be reviewed and accepted as a reasonable application for the sprinkler location. (See attached diagram) · The Maintenance supervisor and/or Administrator will be responsible to see that this is maintained. · This is done as of 12/5/2011.	
K0064 SS=D	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers in the kitchen were readily accessible. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice	K0064	· The area around the noted extinguishers has been cleared to provide ample access to the devices at all times. · Staff has been instructed to maintain this access space at all times. · Area is to remain accessible and items that may prevent this have been removed to prevent reoccurrence. · Dietary Manager and/or designee will be responsible to see that the area is maintained at all times. · This is done as	11/30/2011

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	affects 4 kitchen staff. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:20 p.m., two portable K class fire extinguishers were located in the kitchen; one behind a stack of empty card board cartons near the north exit door and a second behind a five foot kitchen utility service cart. The maintenance director agreed at the time of observations, the use of the fire extinguishers could be impeded by these obstructions. 3.1-19(b)		of 11/30/2011.	
K0075 SS=E	Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles with a total	K0075	· Barrels have been removed from the cited rooms, and are no longer used in any resident rooms. · Barrels of 28-32	12/22/2011

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	capacity exceeding 32 gallons capacity were not stored within any 64 square foot area in 1 of 8 smoke compartments. This deficient practice a affects visitors, staff and 28 residents on the MS unit. Findings include: Based on observation with the maintenance director on 11/22/11 at 1:40 p.m., two 28 to 32 gallon soiled linen and trash receptacles were observed sitting side by side through the open resident room door of room 24. The receptacles were half or more full and had the capacity for 28 to 32 gallons. The maintenance director said at the time of observation, the receptacles were for special isolation trash and soiled linen collection. 3.1-19(b)		yellow size will no longer be used in resident rooms for isolation procedures. Containers of proper size have been ordered to not exceed the recommended size for resident room use. · Containers of the correct size will now be used for isolation procedures. This will prevent further recurrence. · The Housekeeping supervisor and DON or designee will be responsible to see that the correct items are used in isolation procedures. i.e.: containers · This is done as of 12/22/2011.	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations, was stored in an area where electrical fixtures were at least 5 feet (60 inches) above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect 4 or more staff and service contractors evacuated through the service hall	K0143	· The switch has been relocated to the correct height of not less than five (5) feet above the floor. · The correction is permanent in nature and would not be required to be done again. · The moving of the switch meets the current code as required. · The Maintenance supervisor will be responsible to see that this is maintained. · Done as of 12/6/2011.	12/06/2011

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	in the event of an emergency. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:10 p.m., the oxygen storage room had four 181 liter capacity liquid oxygen storage tanks stored in the room with one electrical light switch on the wall 48 inches above the floor. The maintenance director said at the time of observation, he was unaware the light switch location could cause a problem. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions,	K0144	· The recording form for the "GAS" generator has been revised to include the operating temperature as required. · Currently the generator is run on a weekly basis to assure the operation of the equipment.	12/06/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 E SR 16 BROOK, IN47922

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include:		· Continue to perform weekly and monthly operation checks to assure the generator is in operational condition as needed. · The Maintenance supervisor and/or designee are responsible to see that the generator is maintained and operations recorded. · This is done as of 12/6/11.	

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	Based on review of the emergency Generator Run Test Log and maintenance records for the diesel generator with the maintenance director on 11/22/11 at 1:30 p.m., the emergency generator was tested monthly under load for 30 minutes, however, the monthly load test record did not include the percentage of the load carried or minimum operating exhaust temperature readings. The maintenance director said at the time of record review, he did not know the percentage of the load carried, had no temperature documentation, and there had been no load bank testing. 3.1-19(b)			
K0147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible	K0147	· The cord has been removed and disposed of and will no longer be used for the cited equipment. · Staff is aware that extension cords are not to be used on any permanent use device. · The use of extension cords is prohibited and	11/23/2011

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	cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents in the lobby smoke compartment. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:30 p.m., an extension cord was plugged into the cord used to power the window air conditioner in the director of nurses office. The maintenance director said at the time of observation, extension cords were not approved for use in the facility. 3.1-19(b)		staff is instructed during annual safety in-service to not use extension cords for any reason. · This will be monitored by the Maintenance and Housekeeping supervisor and staff during weekly walk thru rounds so as to prevent recurrence. · This is done as of 11/23/11.	
K0154 SS=F	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed to protect 56 of 56	K0154	· The current fire watch policy has been revised to include the sprinkler system(s) and the proper procedure to follow when needed. (See attached 1 and 2)	12/06/2011

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	residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department to be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also to be notified. This deficient practice could affect all occupants. Findings include: Based on review of the facility's policy and procedures with the maintenance director on 11/22/11 at 3:25 p.m., there was no fire watch procedure for an out of service automatic sprinkler system. The maintenance director said at the time of the record review, he was not aware of the requirement.		· The revised policy now includes the additional process needed to provide for proper applications of the policy. · The policy will be revised as needed to maintain a current and applicable policy, so as to prevent further occurrence. · The Administrator or designee and Maintenance supervisor will be responsible to maintain and revise the policy as needed to maintain compliance. · This is done as of 12/6/2011.	

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	3.1-19(b)			
K0155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on observation and interview the facility failed to provide a complete written policy containing procedures to be followed to protect 56 of 56 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the	K0155	· The current fire watch policy has been revised to include the sprinkler system(s) and the proper procedure to follow when needed. · The revised policy now includes the additional process needed to provide for proper applications of the policy. · The policy will be revised as needed to maintain a current and applicable policy, so as to prevent further occurrence. · The Administrator or designee and Maintenance supervisor will be responsible to maintain and revise the policy as needed to maintain compliance. · Staff in-serviced on revised fire watch policy on 12/8/2011.	12/08/2011

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	transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's Fire Panel Monitor Policy provided as evidence of procedures to follow in the event the fire alarm system was out of service with the maintenance director on 11/22/11 at 3:25 p.m., the policy and procedure was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period, the telephone numbers to provide notice to the local fire department and the Indiana State Department of Health, the means by which notice of a fire would be provided to occupants and statements that the			

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	facility's staff were to be trained and designated in regard to the fire watch plan. The maintenance director said at the time of the record review, he was not aware all the elements had not been met. 3.1-19(b)			